

MDR Tracking Number: M5-05-1365-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 1-11-05.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Office visits on 1-16-04, 1-26-04, 2-13-04, 2-27-04, 3-12-04, 3-26-04 and 4-7-04, one unit of manual therapy per encounter, one unit of neuromuscular reeducation per encounter, one unit of therapeutic activities per encounter, three units of therapeutic exercises per encounter and functional capacity evaluations **were found** to be medically necessary. The remaining office visits, therapeutic activities and manual therapy **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 2-1-05 the Medical Review Division submitted a Notice to the requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Review of the requestor's and respondent's documentation revealed that neither party submitted copies of EOB's for dates of service 4-14-04 through 4-28-04. There are no HCFA's in the file. Per Rule 133.307

(e)(2)(A) a copy of all medical bills as originally submitted to the carrier for reconsideration in accordance with 133.304 must accompany disputes filed with a fee component. **Recommend no reimbursement.**

This Finding and Decision is hereby issued this 23<sup>rd</sup> day of March 2005.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees totaling \$6,088.20 outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is applicable to dates of service 1-13-04 through 4-7-04 as outlined above in this dispute.

This Order is hereby issued this 23<sup>rd</sup> day of March 2005.

Margaret Ojeda, Manager  
Medical Necessity Team  
Medical Dispute Resolution  
Medical Review Division

MO/da

Enclosure: IRO decision

# **MEDICAL REVIEW OF TEXAS**

[IRO #5259]

**3402 Vanshire Drive**

**Austin, Texas 78738**

**Phone: 512-402-1400**

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## **NOTICE OF INDEPENDENT REVIEW DETERMINATION**

**REVISED 3/16/05**

TWCC Case Number:	
MDR Tracking Number:	M5-05-1365-01
Name of Patient:	
Name of URA/Payer:	Cotton D. Merritt, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Cotton D. Merritt, DC

March 8, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no

known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD  
Medical Director

cc: Texas Workers Compensation Commission

#### CLINICAL HISTORY

Available documentation received and included for review consists of records from multiple providers including Drs Zumwalt (MD) Merritt (DC), Marshall (MD), Bosscher (MD) Collier (MD) McCarty (DO), Soucy (MD).

Mr. \_\_\_\_, a 68-year-old male, injured his low back, left hip and knee while at work on \_\_\_\_\_. He was lifting some heavy concrete and started to fall, but caught himself on his left lower extremity. He felt a pop and had severe pain in his knee and lateral left hip. He was seen by a Dr. Collier and sent for extensive physical therapy, with little benefit. Orthopedic consult (Soucy) included trochanteric injections. He changed treating doctor to Dr. Merritt, a chiropractor, in early 2003, and a conservative régime of treatment was started for some lower back pain, left hip and left knee pain. Orthopedic referral resulted in a MRI which showed mild to moderate degenerative changes with borderline spinal stenosis throughout the lumbar spine. MRI of the left knee on 7/18/03 revealed moderate degenerative arthritis in the medial compartment, severe complex tear of the posterior horn of the medial meniscus, moderate edema to the articular margin of the left femoral condyle, bowing of an intact medial collateral ligament over the marginal spur formation, moderate thinning of the cartilage posterior to the patella.

Patient underwent total knee replacement on 12/4/03 and followed up with post-surgical rehabilitation. Sequential functional capacity evaluations performed 1/13/04, 3/2/04, 4/5/04, show improving range motion to the left knee, reducing pain and improved function in terms of walking, lifting and self reporting functional activity measures.

#### REQUESTED SERVICE(S)

Medical necessity of office visits (99212), manual therapy (97140), therapeutic exercises, (97110), therapeutic activities (97530), neuromuscular reeducation (97112) functional capacity evaluations (97750-FC). Timeframe in dispute: 01/13/04-04/07/04.

#### DECISION

Approve office visits (99212) on each of the following dates of service. Medical necessity is established for 01/16/04, 01/26/04, 02/13/04, 02/27/04, 03/12/04, 03/26/04, and 4/07/04.

Approve one unit of manual therapy (97140) per encounter.

Approve one unit of neuromuscular reeducation (97112) per encounter.

Approve one unit of therapeutic activities (97530) per encounter.

Approve a maximum of three units of therapeutic exercises (97110) per encounter.

Approve the functional capacity evaluations (97750-FC).

#### RATIONALE/BASIS FOR DECISION

*The standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits) is that an employee who sustained a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.*

This patient sustained injury to the left knee, causing internal derangement, requiring eventual total knee replacement followed by post surgical rehab. The nature of these injuries, in conjunction with the patient's age, places this patient outside of the "normal" expected parameters of 6-8 weeks recovery time.

According to the documentation, treatment consisted of 45 minutes of therapeutic activities, 30 minutes of kinetic activities, 30 minutes of manual therapy and 30 minutes of neuromuscular reeducation between 1/16/04 and 3/17/04. From 3/19/04 onward no kinetic activities were billed, however five units of therapeutic exercises (97110) were performed. Considering the patients diagnosis, a focused post-surgical rehabilitation program would appropriately include the above components. However, considering the combination of interventions, necessity is not established for 30 minutes each of myofascial release and "kinetic activities". These would most likely be preparatory procedures for the exercises, and somewhat duplicative when combined with an additional 45 minutes of therapeutic exercises and 30 minutes of neuromuscular re-education and 1 unit of each should be sufficient. Likewise, medical necessity is not established for more than three units (45 minutes) of therapeutic exercises at any one encounter beyond 03/17/04.

Three functional capacity evaluations were performed, in a sequential fashion every month. These can be considered appropriate considering the patients time out of work, the necessity to establish a baseline prior to a rehabilitation program and for tracking purposes/treatment planning as the program progressed.

With respect to the E/M office visits, as the patient was essentially treated on a focused rehabilitation / strengthening program, there is no apparent requirement established for ongoing daily 99212 E/M services to be provided, above and beyond every two weeks. (01/16/04, 01/26/04, 02/13/04, 02/27/04, 03/12/04, 03/26/04, and 4/07/04).

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

**References:**

Hansen DT: Topics in Clinical Chiropractic, 1994, volume one, No. 4, December 1994, pp. 1-8 with the article "Back to Basics: Determining how much care to give and reporting patient progress".

Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen: Giathersburg, MD, 1993;

Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997; chapter 1, pp. 3-25.

Liebenson C. Commentary: Rehabilitation and chiropractic practice. JMPT 1996; 19(2):134140